STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155330	B. WING		01/10/2012
	PROVIDER OR SUPPLIE	R	200 CC	ADDRESS, CITY, STATE, ZIP CODE ONNIE AVE I, IN 47167	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	·	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000	This visit was for Complaint IN00 IN00102083. Complaint IN00 deficiencies relacited. Complaint IN00 Federal/State deallegations are of F431, F514. Unrelated defice Survey dates: Jurvey dates: Jur	or the Investigation of 0101987 and Complaint 0101987 Substantiated, no ated to the allegations are 0102083 Substantiated, efficiencies related to the cited at F157, F309, F327 diencies were cited. anuary 9 and 10, 2012 or 1000223 or 155330 or 1	F0000		
	Medicare: 9				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

000223

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 02/06/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION OF CORRECTION 155330	(X2) MULTIPLE CO A. BUILDING B. WING	00	— СОМ 01/1	e survey pleted 0/2012
	PROVIDER OR SUPPLIER CROSSING	200 CO	ADDRESS, CITY, STATE, ZIP C INNIE AVE I, IN 47167	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	Medicaid: 57 Other: 23 Total: 89				
	Sample: 6				
	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.				
	Quality review completed 1/13/12 Cathy Emswiller RN				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 2 of 46

PRINTED: 02/06/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE : COMPL		
ANDILAN	or correction	155330	A. BUIL		00	01/10/	
		10000	B. WING	_		01/10/	-V 12
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SALEM C	CROSSING				NNIE AVE 1, IN 47167		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0157 SS=D	A facility must impresident; consult physician; and if legal representation member when the the resident which the potential for mintervention; a significantly (i.e., a deteor psychosocial sthreatening condicomplications); a significantly (i.e., existing form of the consequences, of treatment); or a discharge the resident and, if known there is a change in resident and, if known there is a change in resident and the consequences of the facility must be assignment as space a change in resident and the consequences of the facility must be assignment as spaced on interview of the facility must be update the addresident's legal refamily member. Based on interview facility failed to family of a resident and the facility failed to family failed to failed to failed the failed to failed to failed to failed to failed the failed to failed to failed to failed the fai	mediately inform the with the resident's known, notify the resident's ve or an interested family ere is an accident involving in results in injury and has equiring physician gnificant change in the al, mental, or psychosocial erioration in health, mental, tatus in either life tions or clinical need to alter treatment a need to discontinue an eatment due to adverse or to commence a new form a decision to transfer or ident from the facility as a decision to transfer or ident from the facility as a laso promptly notify the nown, the resident's legal interested family member thange in room or roommate decified in §483.15(e)(2); or ent rights under Federal or lations as specified in	FO	157	Preparation and/or execution of this plan of correction in gener or this corrective action in particular, does not constitues admission or agreement by this facility of the facts alleged or conclusion set forth in this statement of deficiencies. The	al, an s	02/09/2012
	Resident D				plan of corrections and specific		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 3 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPLETED
		155330	A. BUI. B. WIN			01/10/2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	₹				
CALEMA	CROSSING				NNIE AVE I, IN 47167	
SALEIVIC	CRUSSING			SALEIVI	i, iiv 47 107	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
					corrective actions are prepare	
	Findings include				and/or executed in compliance	;
				with state and federal		
	1 The alogad ali	inical record of Resident			laws. F-157 Notify of Changes	
					(injury/decline/room,etc)SS=D hat corrective actions(s) will be	
		on 1/9/12 at 1:30 P.M.			accomplished for those reside	
		s admitted to the facility			found to have affected by the	1100
	with diagnoses i	ncluding, but not limited			deficient practice? * Residen	t D
	to, Acute verteb	ral fracture, Urinary tract			hass pased away. How other	
	infection, and D	ementia.			residents having the potential	to
	,				be affected by the same defici	ent
	A Dhysical Ther	any note dated 11/10/11			practice will be identified and	
A Physical Therapy note, dated 11/10/11				what corrective action(s) will b		
		dicated, "Pt [patient] said			taken? * All resident's has the)
	she was feeling	sick at her stomach. Pt			potential to be affected by the	
	said she was not	able to preform [sic] amb			alleged deficient	
	[ambulation] or	standing exercises.			practice. * Licensed nurses we in-serviced on Change of	re
	Reported pt's co	mplaints to nursing."			condition/notification of	
		r			Physician/family by the	
	Nurgas Natas in	aluded the following			DNS/Designee no later than	
		cluded the following			1/31/2012. Post test included	. *
	notations:				Non-compiance will result in	
					further education including	
	11/10/11 at 10:0	0 P.M.:Alert to person			disciplinary action. *	
	[with] periods of	f confusionResident had			DNS/Designee is responsible	to
	[2] episodes of 'o	dry heaves' or vomitting			ensure compliance. Whate	
		phlegm. Refuses to eat or			measures will be put tinto place or what systemic changes will	
		except for occasional sips			made to ensure that the efficie	
					practice does not recur?* All	110
		O [complains of] stomach			licensed nurse were in-service	d
		sounds] barely audible			on change of	
	but somewhat ac	ctive x 4 quads"			condition/notifications of	
					Physician/family by the	
	11/11/11 at 12:3	5 A.M.: "Refused fluids			DNS/designee no later than	
	tonight"				1/31/2012. Post test included	
					Twenty-four hour report sheets	
	11/11/11 -4 2:00	DM. " o/o no this			new orders and documentation	
		P.M.: "c/o nausea this			will be reviewed daily to identi	′
	day. Is drinking	sprite eating saltines"			residents with a change in	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155330 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE	
STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER 200 CONNIE AVE SALEM CROSSING SALEM, IN 47167	
CROSS-REFERENCED TO THE APPROPRIATE	(X5) MPLETION DATE
condition.* Residents identified will be further reviewed to ensure Physician/family notification was completed and timely.* I1/12/11 at 6:30 P.M.: "Rsd [resident] lethargicunable to bear weight @ this timeFamily (nurse in family) request CXR [chest x-ray], will obtain UA [urinalysis] as well per [name of physician]." Documentation regarding physician or family notification of the resident's nausea was lacking in the clinical record. 2. On 1/10/12 at 12:00 P.M., the Director of Nursing provided the current facility policy on "Resident Change of Condition," revised 3/10. The policy included: "It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention occursAcute Medical Change, a. Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation. The licensed nurse in charge	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 5 of 46

PRINTED: 02/06/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155330		A. BUILDING B. WING	COMPLETED 01/10/2012			
	ROVIDER OR SUPPLIER CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 200 CONNIE AVE SALEM, IN 47167				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	COMPLETION			
	will notify the physicianRoutine Medical Change, a. All symptoms and unusual signs will be documented in the medical record and communicated to the attending physician promptly. Routine changes are a minor change in physical and mental behaviorThe nurse in charge is responsible for notification of physician and family/responsible party prior to end of assigned shift when a significant change in the resident's condition is noted" This federal tag relates to Complaint IN00102083. 3.1-5(a)(1)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 6 of 46

PRINTED: 02/06/2012 FORM APPROVED OMB NO. 0938-0391

SALEM, IN 47167 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL. TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SALEM, IN 47167 PREFIX (PROVIDENCE TANDER TANDER CORRECTION (PAGICORRICATIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY OF THE APPROPRIA	AND PLAN O	T OF DEFICIENCIES DF CORRECTION ROVIDER OR SUPPLIE	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155330	200 CO	00 ADDRESS, CITY, STATE, ZII	——————————————————————————————————————	TE SURVEY MPLETED 10/2012
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	SALEM C	ROSSING		SALEM	, IN 47167		
	PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	CORRECTION N SHOULD BE HE APPROPRIATE)	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 7 of 46

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED		
		155330	B. WIN			01/10/	2012	
			В. W II V		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIEF	₹			NNIE AVE			
SALEM (CROSSING				I, IN 47167			
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES	ı	ID			(X5)	
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
F0282		vided or arranged by the						
SS=D		rovided by qualified persons						
	,	th each resident's written						
	plan of care.		F0	282				
	A. Based on obs	servation, interview, and			F-282. Services by qualified		02/09/2012	
	record review, th	he facility failed to ensure			persons/per care plan. SS = DWhat corrective actions(s) w	:11		
	physician's order	rs were followed for 2 of			be accomplished for those	III		
	5 residents revie	ewed related to following			residents found to have been			
	physician's order	rs in a sample of 6.			affected by the deficient			
	(Residents A and	d C)			practice?* Resident C is wear	•		
		,			TED house and oxygen per or	der		
	R Rased on obs	servation and interview,			as well as receiving oxygen therapy per order. Resident C			
	the facility failed to ensure oxygen				also had no negative outcome			
					while O2 was being filled and			
		iated by qualified staff for			restriction is being monitored.*			
		eviewed related to oxygen			Resident A is wearing the ede			
	therapy in a sam	ple of 6. (Resident C)			glove per order and BM's			
					monitored to ensure every 3			
	Findings include	2:			days. How other residents have the potential to be affected by			
					same deficient practice will be	uie		
	A. 1. The clinica	al record for Resident C			identified and what corrective			
	was reviewed on	n 1/9/12 at 12:05 p.m.			action(s) will be taken?* All			
		•			residents have the potential to			
	A Physician's (Orders for January 2012			affected by the alleged deficie			
		ere not limited to, "TED			practice. * Licensed Nursing s			
	· · ·	,			has been in-serviced on follow physicians orders/administerin			
		ned/reg [medium/regular]			oxygen therapy by the	9		
		to bilateral lower			DNS/designee no later than			
		n morning off daily at			1/31/2012. Post test			
	bedtime."				completed. * C.N.A's has bee	n		
					in-serviced on accomodation of			
	During observat	ion of personal care for			needs-i.e., - applying TED hos	se,		
	Resident C on 1/	/9/12 at 10:40 a.m., CNA			edeman glove etc., fluid	~		
		assisted Resident A to			restrictions/blue form and filling and turning on oxygen by the	y		
		ocks. The resident's right			DNS/Designee no later than			
	-	bserved to be swollen.			1/31/2012. Post test included.	*		
	-	v at this time, CNA #7			All physicians order are review			
	i During interviev	v at uns unie. CNA #/	1		İ		l	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet Page 8 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED	
		155330	B. WIN			01/10/2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			NNIE AVE		
SALEMO	CROSSING				I, IN 47167		
					,	775	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	ì ·	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA'	TE COMPLETION DATE	
TAG		*		TAG	daily by the DNS/designee wit		
		ident's leg would swell			follow-up using the CQI minute		
		rgery on her leg. CNA #5			tool to ensure physician orders		
		ce Resident C's right shoe			are in place and being follower		
	on her foot. Du	ring interview at this time,			100% audit of BM records		
	CNA # 5 indicat	ed the shoe would not fit			conducted to identify any		
	on the foot due t	o swelling, and placed			residents that have not had a l	l l	
	slipper socks on	the resident. No			every 3 days. * BM records ar reviewed daily by the	е	
		tic deterrent (TED) hose			DNS/designee to ensure		
		be placed on the			residents have gone no longer	·	
	resident's legs.	o oo piaooa on mo			than 3 days without a BM.		
	resident s legs.				Appropriate steps will be taker		
	Desire a alexande	: : 4bbi1			a resident is noted to not have		
		ion in the physical			BM on day 3. * Residents on	l l	
		1/9/12 at 1:45 p.m.,			fluid restriction will have a blue food and fluid consumption	;	
		observed with leg weights			record to alert staff when a		
	on the lower leg	s. The Physical Therapist			resident is on fluid restriction.		
	Assistant (PTA)	was working with the			The amount of restrictive fluids	3	
	resident. During	g interview at this time,			given will include dietary and		
	the PTA indicate	ed the resident was not			nursing with a total amount of		
	wearing TED ho	ose.			fluids consumed in a 24 hr per		
	Č				documented on same form. * 100% audit completed to ensu		
	On 1/10/11 at 10):10 a.m. the PTA was			c.n.a. assignment sheets and		
		Resident C in her wheel			care plans to ensure appropria	ate	
	_				interventions are included to		
		ctivity Room into the TV			reflect fluid restrictions, edema	à	
		interview at this time,			glove, TED hose etc.* Daily		
		ed the resident was not			rounds will be completed daily	by	
	•	ose. The PTA indicated			a licensed nurse to ensure residents are receiving O2 per		
	the resident had	worn TEDs previously.			Physicians order. *		
					None-compliance with these		
	During interview	v on 1/9/12 at 11:20 a.m.,			practices will result in further		
	1	ted the resident was			education including disciplinar	y	
		vearing TED hose. LPN			action. * Director of Nursing		
		e hose had been in the			services/designee is responsible	ole	
		re returned to her office.			to ensure compliance. What measures will be put into place	e or	
					what systemic changes will be		
	LPN #12 indicat	ted the resident "has them			what systemic changes will be		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 9 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED
		155330	B. WIN			01/10/2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	8			ONNIE AVE	
SALEMO	CROSSING				I, IN 47167	
					.,	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)		TAG	·	
	on now."				made to ensure that the deficient practice does not recur? *	ent
					Licensed Nursing staff has be	<u>-n</u>
	B. A Physician	Telephone Order, dated			in-serviced on following	
	1/1/12, indicated	l, "Cleanse split behind			physicians orders/administerin	g l
	right ear daily [s	ymbol for with] NS			oxygen therapy by the	
		oat dry apply TAO [triple			DNS/designee no later than	
		ent] & guaze [sic] dly			1/31/2012. Post test included	
		as needed]. Keep oxyears			C.N.A's has been in-serviced of accomodation of	on
	on oxygen tubin				needs-i.e.,-applying TED hose	,
	on oxygen tubin	g at all tilles.			edema glove etc., fluid	''
	.	1 (0/10			restrictions/blue form and filling	g l
During the personal care on 1/9/12 at				and turning on oxygen-by the		
	· · · · · · · · · · · · · · · · · · ·	dent C was observed to			DNS/Designee no later than	
	have a small dre	ssing on the right ear.			1/31/2012. Post test included	*
	CNA #7 indicate	ed the resident had a			All physician orders are	
	"place on her ear	r - probably from the			reviewed daily by the	
	•	No padding was			DNS/Designee with follow-up using the CQI minutes tool to	
	observed on the				ensure physician orders are in	
	ooser vea on the	tuomg.			place and being followed. * I	
	On 1/10/12 at 10	0:10 a.m., Resident C was			records are reviewed daily by	the
		wheel chair in the TV			DNS/Designee to ensure	
					residents have gone no longer	•
		ding was observed on the			than 3 days without a BM. Appropriate steps will be taker	, if
		round the resident's ears.			a resident is noted to not have	
	During interviev	v at this time, the PTA			BM on day 3. * Residents on	
	indicated the res	ident had no padding on			fluid restriction will have a blue	
	the oxygen tubir	ng.			food and fluid consumption	
	-				record to alert staff when a	
	During interview	v on 1/10/12 at 10:55			residnet is on a fluid restriction	
		indicated oxyears are a			The amount of restrictive fluids	
	· ·	oxygen tubing. She			will include dietary and nursing with a total amount of fluids	9
		ent C "now has oxyears on			consumed in a 24 hr period	
		•			documented on same	
	[the oxygen tubi	ngj.			form. * Daily rounds will be	
					completed by licensed nurse to	0
	<u>-</u>	rders for January 2012			ensure oxygen use is on	
	included, but we	ere not limited to, "Fluid			per Physician. * Non-complia	nce

NAME OF PROVIDER OR SUPPLIER SALEM CROSSING STREET ADDRESS, CITY, STATE, ZIP CODE 200 CONNIE AVE 200 CONNIE AVE SALEM, IN 47167 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TO PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TO PROVIDERS PLAN OF CORRECTION COMPLETION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) With these practices will result in		NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 CONNIE AVE SALEM CROSSING (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG With these practices will result in	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00		
NAME OF PROVIDER OR SUPPLIER SALEM CROSSING 200 CONNIE AVE SALEM, IN 47167 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG With these practices will result in			155330	B. WING	<u> </u>		01/10/	2012
PREFIX TAG CEACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX CEACH CORRECTION CHEACH CORRECTION CHEACH CORRECTION CHEACH CORRECTION CHEACH CORRECTION CHEACH CORRECTION COMPLETION DATE COMPLETION DATE With these practices will result in					200 COI	NNIE AVE		
	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	P	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
On 1/9/11 at 1:30 p.m., Resident C was observed being wheeled from the dining room. CNA #9 was observed to be removing dishes and glasses from Resident A's place at the table. During interview at this time, CNA #9 indicated three glasses of thickened liquids on the table at Resident A's place were for Resident A. CNA #5 was also in the dining room and indicated Resident A does not like her thickened liquids. The Food/Fluid Intake Record for January 2012 indicated the following fluid consumption in cubic centimeters during the first week of January 2012: 1/1/12: 1070; 1/5/12: 580; 1/6/12: 720; 1/7/12: 720. The Medication Record for January 2012 indicated the following fluid consumption in cubic centimeters during the first week of January 2012: 1/1/12: 340 (no fluid consumption documentation on second shift); 1/3/12: 300; 1/4/12: 260; 1/5/12: 210; 1/6/12: 210 (no fluid consumption documentation on second shift); 1/7/12: 420. Total fluid intake for the dates indicated were: 1/1/12; 1550; 1/2/12: 1540; 1/3/12:		On 1/9/11 at 1:30 observed being we room. CNA #9 or removing dishes Resident A's plan interview at this three glasses of table at Resident Resident A. CN dining room and does not like her. The Food/Fluid 2012 indicated the consumption in the first week of 1070; 1/2/11: 12 1070; 1/5/12: 58 720. The Medication indicated the folion cubic centime of January 2012: 340 (no fluid coron second shift); 260; 1/5/12: 210 consumption does shift); 1/7/12: 42	O p.m., Resident C was wheeled from the dining was observed to be and glasses from the at the table. During time, CNA #9 indicated hickened liquids on the A's place were for A #5 was also in the indicated Resident A thickened liquids. Intake Record for January the following fluid eubic centimeters during January 2012: 1/1/12: 00; 1/3/12: 1080; 1/4/12: 0; 1/6/12: 720; 1/7/12: Record for January 2012 dowing fluid consumption ters during the first week 1/1/12: 480; 1/2/12: insumption documentation 1/3/12: 300; 1/4/12: 0; 1/6/12: 210 (no fluid cumentation on second 0.			further education including disciplinary action. How the corrective action(s) will be monitored to ensure the defici practice will not recur, i.e., wh quality assurance program will put into place? * The CQI aud tools for bowel elimination and fluid restrictions will be utilized weekly x 4 weeks, bi-weekly x months, monthly x 3 months a quarterly thereafter. * The CQI audit tool for oxygen therapy accoumodation of needs will be utilized weekly x 4, b-weekly x months, monthly x 3 months a quarterly thereafter. * The CQI audit tool for c.n.a. assignments sheet will be utilized weekly x bi-weekly x 2 months, monthly x 3 months, monthly x 3 months, and the control of the c.n.a. assignments will be utilized weekly x bi-weekly x 2 months, monthly x 3 monthly x 3 months x 3 monthly x 3	ent at I be dit I S 2 and DI and De S 2 and DI and DI and DI t 4,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 11 of 46

PRINTED: 02/06/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155330	B. WING		01/10/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	IR.		ONNIE AVE	
SALEM (CROSSING			1, IN 47167	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	1	(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	1380: 1/4/12: 1	330; 1/5/12: 790; 1/6/12:			
	1040; and 1/7/1				
	1040, and 1///1	2. 1140.			
	During intervie	w on 1/9/12 at 3:10 p.m.,			
	_	ated the CNAs documented			
	_	on on the Food/Fluid			
	-	and nurses documented			
	_	on on the Medication			
	Record.				
	D DI	1 C I 2012			
	D. Physician's orders for January 2012				
	included, but were not limited to, "O2				
	1	PM [liters per minute]			
	_	s] to keep sats > [greater			
	than] 90%."				
		45 p.m., Resident C was			
		physical therapy room,			
		neel chair with leg weights			
	,	gs. The Physical Therapist			
	Assistant (PTA)) was working with the			
	resident to perfe	orm leg lifts. The resident			
	had a nasal can	ula to the nose, and oxygen			
	tubing led towa	rd the back of the wheel			
	chair. No porta	ble oxygen tank was on			
	_	resident's wheel chair.			
	During interview	w at this time, the PTA			
	_	ortable oxygen tank had			
	_	filling. The PTA obtained			
		ration meter and applied it			
		finger. He indicated the			
		actuated but was at the			
	95-96% range.	ictuated but was at tile			
	93-90% range.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 12 of 46

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155330	LDING	NSTRUCTION 00	COMP	ESURVEY LETED 0/2012
	PROVIDER OR SUPPLIER		200 CO	.DDRESS, CITY, STATE, ZIP COE NNIE AVE , IN 47167	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	2. The clinical reviewed on 1/9/	ecord for Resident A was 12 at 2:00 p.m.				
	included, but we received 10/14/1 edema glove to l wheelchair to de range of motion	rders for January 2012 re not limited to, an order 0, for "Patient to wear eft hand when up in crease edema/increase in left hand."				
	observed seated high-backed who	in her room in her eelchair. The resident's served to be swollen, and				
	observed seated wheelchair in the	:35 a.m., Resident A was in her high-backed e hall near the nurse's na glove was on the left nd was swollen.				
	observed during assistance of CN resident's left har she was transfer. The left hand wa glove was in pla arm fell limply to positioned her for interview at this the resident does	40 p.m. Resident A was toileting with the A #9 and CNA #11. The and was on a pillow before red from chair to toilet. It is swollen, and no edema red. The resident's left to her side as the CNAs or transfer. During time, CNA #9 indicated a not refuse to wear the red indicated she thought				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 13 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155330	B. WING		01/10/2012
NAME OF E	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
				ONNIE AVE	
SALEM	CROSSING		SALEN	Л, IN 47167	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		ot available, because the			
	1	t home sometimes for			
	washing.				
	1	orders for January 2010			
	-	ere not limited to, an order			
		7/20/10, for "Milk of			
		a] sus [suspension], give			
		for no bowel movement			
	in 3 days."				
	`	vities of Daily Living)			
		d the resident had a large			
		nt on day shift on 1/4/12.			
		el movement was			
		shift through day shift on			
	1/9/12.				
	TO 1	D 1: 1: 4 14			
		Record indicated the			
		arge bowel movement on			
	the 6:00 a.m. to	2:00 p.m. shift on 1/3/11.			
	N. C. (1. 1	1			
		el movements were			
		ADL Record or			
		ord through the time of			
		from 1/4/12 through 1/9/12			
	at 2:00 p.m., a p	period of five days.			
	The Marine	D 1 C. 11 . 14 . 1 . 11 . 4			
		Record failed to indicate			
		eived the ordered Milk of			
	Magnesia.				
	December	In MI and MI (CH 1)			
		in Nurse's Notes failed to			
	indicate the resi	dent had a bowel			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet Page 14 of 46

	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 155330	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM 01/1	TE SURVEY IPLETED 10/2012	
	PROVIDER OR SUPPLIER CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 200 CONNIE AVE SALEM, IN 47167				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	movement or received the ordered Milk of Magnesia.					
	During interview on 1/10/12 at 2:10 p.m., the Director of Nursing (DON) indicated the resident had a large bowel movement on evening shift on 1/9/12, and showed the ADL Record for the shift. The DON indicated the record did not have other information about bowel between movements between 1/4 and 1/9/12. She indicated she thought the resident must have received a laxative, since the resident had a large bowel movement on 1/9/12. The DON indicated administration of a laxative was not indicated in the record. B. During observation of personal care for Resident C on 1/9/12 at 10:40 a.m., CNA #5 and CNA #7 assisted Resident A to transfer from bed to wheel chair. The resident was wearing oxygen tubing connected to the oxygen concentrator set at 2. The tubing was switched to a portable oxygen tank hanging at the back of the resident's wheel chair, and CNA #7 turned the dial setting on the portable oxygen tank to "2." CNA #5 was overheard to say, "There's a little still in it" in regard to the tank. During interview at this time, CNA #5 indicated they would set the dial on the portable tank based on the setting on the concentrator or as					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 15 of 46

PRINTED: 02/06/2012 FORM APPROVED OMB NO. 0938-0391

		DENTIFICATION NUMBER: 155330	A. BUII B. WIN	LDING	00	COMPL 01/10/	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 CONNIE AVE SALEM, IN 47167				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PERCEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	indicated on the CCNA #5 indicated correct setting], we review of the CN provided by the A Tour of the facilit a.m., indicated no Resident C's oxyg 1/10/12 at 11:30 a Nursing indicated a policy related to therapy. She indicent CNA could not choxygen flow rate,	CNA Assignment Sheet. If if they "don't know [the re go ask." IA Assignment Sheet DON during the Initial yon 1/9/12 at 10:30 instruction related to gen. During interview on a.m., the Director of the facility did not have provision of oxygen cated she thought the hange settings for the but that the CNA would the dial of the portable					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet Page 16 of 46

PRINTED: 02/06/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155330	B. WING		01/10/2012		
NAME OF P	PROVIDER OR SUPPLIEI	3	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
			200 CONNIE AVE				
SALEM C	CROSSING		SALEM	I, IN 47167			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet Page 17 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155330		(X2) MULTIPLE CO	ONSTRUCTION 00	COMPI	COMPLETED 01/10/2012	
			B. WING	A DDDDDGG G		
	ROVIDER OR SUPPLIER	t.	200 CC	ADDRESS, CITY, STATE, ZIP COD DNNIE AVE 11, IN 47167	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	Each resident mumust provide the services to attain practicable physipsychosocial well the comprehensicare. Based on observinterview, the fawas planned and low blood sodium residents review sodium levels (Rorelated to edema of 2 residents review in a sample of 6. The facility also management of to of 5 residents remanagement in a C) Findings included 1. A. During ob for Resident C on CNA #5 and CN to don pants and right lower leg was well since she had CNA #5 attempto.	ust receive and the facility necessary care and or maintain the highest cal, mental, and l-being, in accordance with we assessment and plan of ation, record review, and cility failed to ensure care implemented related to m levels for 1 of 2 ed related to blood desident C) and care of the extremities for 2 wiewed related to edema (Residents A and C) failed to ensure the bowel regimen for 1 eviewed related to bowel a sample of 6. (Resident A socks. The resident's vas observed to be ginterview at this time, ed the resident's leg would had surgery on her leg. ed to place Resident C's		F-309 Provide care/service Highest well being. SS = corrective action(s) will be accomplished for those refound to have been affect the deficient practice? * C is wearing TED hose porder. * Residents C's cand c.n.a. assignment should be plan of care relating to flurestriction. * Resident A wearing the edema glove order and BM's are monitioned ensure at least every 3 dother residents having the potential to be affected by same deficient practice widentified and what correction(s) will be taken?* residents have the potential fected by the alleged depractice.* Licensed Nurshas been in-serviced on the physicians orders by the DNS/Designee no later 1/31/2012. Post test included the care plans have been upensure all interventions a place. * All physician order eviewed daily by the DNS/designee. Physician	ce for DWhat e esidents ted by Resident er are plan eets has currect uid is per tored to ays. How e y the vill be ctive All tial to be eficient ing staff following uded. * ts and dated to re in lers are	
	_	foot. During interview A # 5 indicated the shoe		are in place and are being followed. * BM records a	g	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 18 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUILDING	A. BUILDING 00 COMPLETED		
		155330			01/10/2012	
			B. WING	CADDRESS CITY STATE TIN CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER		T ADDRESS, CITY, STATE, ZIP CODE		
				ONNIE AVE		
SALEM CROSSING		SALE	M, IN 47167			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	would not fit or	n the foot due to swelling,		reviewed daily by the		
		per socks on the resident.		DNS/Designee to ensure		
	1	abolytic deterrent (TED)		residents have gone no longe	r	
		• • • • • • • • • • • • • • • • • • • •		than 3 days without a BM.	.,	
		rved to be placed on the		Appropriate steps will be take		
	resident's legs.			a resident is noted to not have		
				BM on day 3. * Residents on fluid restriction will have a blu		
	During observa	tion in the physical		food and fluid consumption		
	therapy room o	n 1/9/12 at 1:45 p.m.,		record to alert staff when a		
		s observed with leg weights		residnet is on a fluid restrictio	n.	
		gs. The Physical Therapist		The amount of restrictive fluid		
	1			will be between dietary and		
	`) was working with the		nursing with a total amount of	:	
		ng interview at this time,		fluids consumed in a 24 hr pe	riod	
	the PTA indica	ted the resident was not		documented on same form. *		
	wearing TED h	iose.		Non-compliance with these		
				practices will result in further		
	During observa	tion of the Resident C on		education including disciplina	ry	
	_			action. * Director of Nursing services/designee is responsi	blo	
		0 a.m. the PTA was		to ensure compliance. What	bie	
		g Resident C in her wheel		measures will be put into place	e or	
	chair from the	Activity Room into the TV		what systemic changes will be		
	Lounge. Durin	g interview at this time,		made to ensure that the defic		
	the PTA indica	ted the resident was not		practice does not recur?*		
	wearing TED h	ose. The PTA indicated		Licensed Nursing staff has be	en	
	1	d worn TEDs previously.		in-serviced on following		
	the resident had	I WOIII TEDS picviously.		physicians orders by the		
				DNS/designee no later than		
		CNA Assignment Sheet		1/31/2012. Post test included	1. *	
	provided by the	e ADON during the Initial		All physicians orders are		
	Tour of the faci	ility on 1/9/12 at 10:30		reviewed daily by the DNS/designee with follow up		
	a.m., indicated	no instruction related to		using the CQI minutes tool to		
	Resident C's TED hose.			ensure physician orders are in		
				place and being followed. * E		
	T11' ' 1	and Compositions C		records are reviewed daily by		
		cord for Resident C was		DNS/designee to ensure		
	reviewed on 1/9	9/12 at 12:05 p.m.		residents have gone no longe	r	
				than 3 days without a BM.		
	Nurse's Notes f	For 11/30/11 at 4:30 p.m.		Appropriate steps will be take	n if	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet Page 19 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155330	B. WING			01/10/	2012
			D. WII.	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			NNIE AVE		
SALEM (CROSSING				, IN 47167		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		ler was received for the		1110	a resident is noted to not have	а	Dille
					BM on day 3. * Residents on		
	resident's transf	er to the emergency room.			fluid restriction will have a blue		
	TI 1101: 1 I				food and fluid consumption		
		mpression" on the			record to alert staff when a		
		ysician Record," dated			resident is on a fluid restriction The amount of restrictive fluids		
		ated, "Edema [R with			will be between dietary and	•	
		right] leg." "Physician's			nursing with a total amount of		
	Orders" include	d, but were not limited to,			fluids consumed in a 24 hr per	riod	
	"TED hose both	legs during daytime 0700			documented on same form.*		
	- 1900 [7:00 a.n	n. to 7:00 p.m.]"			None-compliance with these practices will result in		
					further education including		
	Physician's Ord	ers for January 2012			disciplinary action. How the		
	included, but we	ere not limited to, "TED			corrective action(s) will be		
	•	med/reg [medium/regular]			monitored to ensure the defici-		
		to bilateral lower			practice will not recur, i.e., who		
		n morning off daily at			quality assurance program will put into place?* The CQI audi		
	bedtime."	in morning our daily de			tools for bowel elimination,	·	
	beatime.				accommodation of needs and		
	During interview	w on 1/9/12 at 11:20 a.m.,			fluid restrictions will be utilized		
	_	ted the resident was			weekly x 4 weeks, bi-weekly x		
					months, monthly x 2 and quart	erly	
		wearing TED hose. LPN			thereafter.* Findings from the CQI process will be reviewed		
		ne hose had been in the			monthly and an action plan wil	l be	
	• •	ere returned to her office.			implemented for threshold below		
		ted the resident "has them			95%.		
	on now."						
	• •	sonal care for Resident C					
		40 a.m., Resident C was					
		e no fluids at the bedside.					
	CNA #5 indicat	ed the resident received					
	pudding thick li	quids and received the					
	fluids from the	hydration cart. She also					
		resident requested fluids,					
		uids were in the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet Page 20 of 46

	OF CORRECTION OF CORRECTION AFE 220	(X2) MULTIPLE CO A. BUILDING	COMPLETED		
	155330	B. WING		_	10/2012
	PROVIDER OR SUPPLIER CROSSING	200 CO	ADDRESS, CITY, STATE, ZII NNIE AVE , IN 47167	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	refrigerator and could be obtained for the resident.				
	On 1/9/11 at 1:30 p.m., Resident C was observed being wheeled from the dining room. CNA #9 was observed to be removing dishes and glasses from Resident A's place at the table. During interview at this time, CNA #9 indicated three glasses of thickened liquids on the table at Resident A's place were for Resident A. CNA #5 was also in the dining room and indicated Resident A does not like her thickened liquids. The "Clinical Impression" on the "Emergency Physician Record," dated 11/30/11, indicated, "Hyponatremia [low sodium]" with a blood sodium level of 122. "Physician's Orders" included, but were not limited to, "Fluid restriction 1 liter per day" and "BMP [Basic Metabolic Profile including sodium level] 12/1/11." Results of the BMP, dated 12/1/11, indicated a sodium level of "125 (L) [low]" with the reference range of 137 to 145. Physician's Orders for December 2011 and January 2012 included, but were not limited to, "Fluid restriction 1 liter/day."				
	The Care Plan with problem date of				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 21 of 46

PRINTED: 02/06/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155330			LDING	NSTRUCTION 00	(X3) DATE COMPI 01/10		
	PROVIDER OR SUPPLIER		p. wax	STREET A	oddress, city, state, zip code NNIE AVE , IN 47167		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG	11/17/11 indicate imbalance" Ir failed to indicate related to the flu Documentation of Plan was updated related to the flu Review of the Coprovided by the Tour of the facilia.m., indicated n Resident C's fluid During interview	ed, "At risk for fluid atterventions on the plan at the plan was updated and restriction. Sailed to indicate the Care d with interventions and restriction. NA Assignment Sheet ADON during the Initial atty on 1/9/12 at 10:30 or instruction related to d restriction.		TAG	DEFICIENCY)		DATE
	(ADON) indicate should receive w dietary meal care	nt Director of Nursing ed the fluids the resident rould be indicated on her d for fluids received with Medication Record for by nursing.					
	C's dietary meal a.m. Review of indicated the restriction with p. The meal card in amounts of fluid meal. During in 11:55 a.m., the I the resident was	nager provided Resident card on 1/10/12 at 11:05 the card at this time ident had a 1000 cc fluid budding thick liquids. dicated no specific s to be provided at each atterview on 1/10/12 at Dietary Manager indicated to received 180 cc of with each meal and 180 ten meals.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 22 of 46

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155330			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/10/2012
	PROVIDER OR SUPPLIE CROSSING	R	200 CC	ADDRESS, CITY, STATE, ZIP CODE ONNIE AVE I, IN 47167	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Dietary notes fa information rela restriction.	iled to indicate ated to the resident's fluid			
	2012 indicated to consumption in the first week of 1070; 1/2/11: 12	Intake Record for January the following fluid cubic centimeters during f January 2012: 1/1/12: 200; 1/3/12: 1080; 1/4/12: 80; 1/6/12: 720; 1/7/12:			
	indicated the folin cubic centime of January 2012 340 (no fluid coon second shift) 260; 1/5/12: 21	Record for January 2012 flowing fluid consumption eters during the first week 1: 1/1/12: 480; 1/2/12: Insumption documentation 1: 1/3/12: 300; 1/4/12: 0; 1/6/12: 210 (no fluid recumentation on second 20.			
	were: 1/1/12: 1 1/3/12: 1380; 1/	te for the dates indicated (1550; 1/2/12: 1540; 14/12: 1330; 1/5/12: 790; and 1/7/12: 1140.			
	the Director of I revised Care Pla risk for fluid im interview at this	w on 1/10/12 at 2:50 p.m., Nursing (DON) provided a an for the problem of "At balance" During a time, the DON indicated w been revised to indicate			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 23 of 46

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155330		(X2) MULTIPLE CC A. BUILDING B. WING	00	COME	E SURVEY PLETED D/2012	
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZII DNNIE AVE I, IN 47167	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	dietary and the a supplied by nurs	uids to be supplied by mount of fluids to be ing during medication a total of 1000 cc.				
	the DON indicat fluid consumption Intake Record, a	on 1/9/12 at 3:10 p.m., ed the CNAs documented on on the Food/Fluid and nurses document fluid the Medication Record.				
		al record for Resident A 1/9/12 at 2:00 p.m.				
	included, but we received 10/14/1 edema glove to l	rs for January 2012 re not limited to, an order 0, for "Patient to wear eft hand when up in crease edema/increase in left hand."				
	observed seated high-backed who eyes were closed forward onto her hand was visible	2:05 a.m., Resident A was in her room in her eelchair. The resident's and head nodded chest. The resident's left, and no edema glove was The left hand was				
	observed seated wheelchair in the	:35 a.m., Resident A was in her high-backed e hall near the nurse's na glove was on the left				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 24 of 46

PRINTED: 02/06/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	NSTRUCTION	COMPL		
AND FLAN	OF CORRECTION	155330	A. BUI	LDING	00	01/10/	
		199330	B. WIN			01/10/	2012
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SALEM (CROSSING				NNIE AVE , IN 47167		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	hand. The left has	and was swollen.					
	On 1/10/12 at 1: observed during assistance of CN resident's left har she was transferr The left hand wa glove was in plac arm fell limply to positioned her for interview at this the resident does edema glove. Sh the glove was no daughter takes it washing. B. Physician's or included, but we originally dated 'Magn [magnesia 30 ml as needed in 3 days." Phys 2012 also include Docusate Sodium The ADL (Active Record indicated bowel movemen No further bowe	40 p.m. Resident A was toileting with the A #9 and CNA #11. The and was on a pillow before red from chair to toilet. It is swollen, and no edema ce. The resident's left to her side as the CNAs or transfer. During time, CNA #9 indicated anot refuse to wear the ne indicated she thought at available, because the home sometimes for more refused to, an order 7/20/10, for "Milk of I sus [suspension], give for no bowel movement ician's orders for January ed orders for Miralax and in for constipation. It it is of Daily Living I the resident had a large to no day shift on 1/4/12.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 25 of 46

NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155330	A. BUI	LDING	NSTRUCTION 00	COMP	ESURVEY LETED 0/2012
		<i>5.</i> W2.	STREET A	NNIE AVE	DE	
(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
resident had a lathe 6:00 a.m. to	rge bowel movement on 2:00 p.m. shift on 1/3/12.					
indicated on the Medication Record review, fr at 2:00 p.m., a po	ADL Record or ord through the time of from 1/4/12 through 1/9/12 eriod of five days.					
indicate the residence movement or recommendate.	dent had a bowel seived the ordered Milk of					
the Director of N the resident had on evening shift the ADL Record this. The DON in not have other in bowel between 1 indicated she that have received a 1 resident had a la 1/9/12. The DO	Jursing (DON) indicated a large bowel movement on 1/9/12, and showed for the shift indicating indicated the record did aformation about the 1/4 and 1/9/12. She bught the resident must laxative, since the rge bowel movement on N indicated					
	PROVIDER OR SUPPLIER CROSSING SUMMARY S' (EACH DEFICIEN REGULATORY OR The Medication resident had a lathe 6:00 a.m. to a No documentation. No further bowe indicated on the Medication Record review, first at 2:00 p.m., a position of the resident recent Magnesia. Documentation in indicate the resident recent Magnesia or had the bowel. During interview the Director of Nother resident had on evening shift the ADL Record this. The DON in the nother in bowel between 1 indicated she the have received a 1 resident had a late 1/9/12. The DO	PROVIDER OR SUPPLIER CROSSING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The Medication Record indicated the resident had a large bowel movement on the 6:00 a.m. to 2:00 p.m. shift on 1/3/12. No documentation on the No further bowel movements were indicated on the ADL Record or Medication Record through the time of record review, from 1/4/12 through 1/9/12 at 2:00 p.m., a period of five days. The Medication Record failed to indicate the resident received the ordered Milk of Magnesia. Documentation in Nurse's Notes failed to indicate the resident had a bowel movement or received the ordered Milk of Magnesia or had been assessed related to	PROVIDER OR SUPPLIER CROSSING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The Medication Record indicated the resident had a large bowel movement on the 6:00 a.m. to 2:00 p.m. shift on 1/3/12. No documentation on the No further bowel movements were indicated on the ADL Record or Medication Record through the time of record review, from 1/4/12 through 1/9/12 at 2:00 p.m., a period of five days. The Medication Record failed to indicate the resident received the ordered Milk of Magnesia. Documentation in Nurse's Notes failed to indicate the resident had a bowel movement or received the ordered Milk of Magnesia or had been assessed related to the bowel. During interview on 1/10/12 at 2:10 p.m., the Director of Nursing (DON) indicated the resident had a large bowel movement on evening shift on 1/9/12, and showed the ADL Record for the shift indicating this. The DON indicated the record did not have other information about the bowel between 1/4 and 1/9/12. She indicated she thought the resident must have received a laxative, since the resident had a large bowel movement on 1/9/12. The DON indicated	PROVIDER OR SUPPLIER CROSSING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The Medication Record indicated the resident had a large bowel movement on the 6:00 a.m. to 2:00 p.m. shift on 1/3/12. No documentation on the No further bowel movements were indicated on the ADL Record or Medication Record through the time of record review, from 1/4/12 through 1/9/12 at 2:00 p.m., a period of five days. The Medication Record failed to indicate the resident received the ordered Milk of Magnesia. Documentation in Nurse's Notes failed to indicate the resident had a bowel movement or received the ordered Milk of Magnesia or had been assessed related to the bowel. During interview on 1/10/12 at 2:10 p.m., the Director of Nursing (DON) indicated the resident had a large bowel movement on evening shift on 1/9/12, and showed the ADL Record for the shift indicating this. The DON indicated the record did not have other information about the bowel between 1/4 and 1/9/12. She indicated she thought the resident must have received a laxative, since the resident had a large bowel movement on 1/9/12. The DON indicated	PROVIDER OR SUPPLIER CROSSING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE FRECDED BY FULL REGULATORY OR LSC DEENTFYING INFORMATION) The Medication Record indicated the resident had a large bowel movement on the 6:00 a.m. to 2:00 p.m. shift on 1/3/12. No documentation on the Medication Record through the time of record review, from 1/4/12 through 1/9/12 at 2:00 p.m., a period of five days. The Medication Record failed to indicate the resident received the ordered Milk of Magnesia. Documentation in Nurse's Notes failed to indicate the resident received the ordered Milk of Magnesia or had been assessed related to the bowel. During interview on 1/10/12 at 2:10 p.m., the Director of Nursing (DON) indicated the resident had a large bowel movement on evening shift on 1/9/12, and showed the ADL Record for the shift indicating this. The DON indicated the record did not have other information about the bowel between 1/4 and 1/9/12. She indicated she thought the resident must have received a laxative, since the resident had a large bowel movement on 1/9/12. The DON indicated	OF CORRECTION IDENTIFICATION NUMBER: 155330 REPROVIDER OR SUPPLIER CROSSING SUMMARY STATEMENT OF DEFICIENCIES (REACH DEPICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The Medication Record indicated the resident had a large bowel movement on the 6:00 a.m. to 2:00 p.m. shift on 1/3/12. No documentation on the No further bowel movements were indicated on the ADL Record or Medication Record through the time of record review, from 1/4/12 through 1/9/12 at 2:00 p.m., a period of five days. The Medication Record failed to indicate the resident received the ordered Milk of Magnesia. Documentation in Nurse's Notes failed to indicate the resident received the ordered Milk of Magnesia or had been assessed related to the bowel. During interview on 1/10/12 at 2:10 p.m., the Director of Nursing (DON) indicated the resident had a large bowel movement on evening shift on 1/9/12, and showed the ADL Record for the shift indicating this. The DON indicated the record did not have other information about the bowel between 1/4 and 1/9/12. She indicated she thought the resident must have received a laxative, since the resident had a large bowel movement on 1/9/12. The DON indicated

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 26 of 46

PRINTED: 02/06/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			
		155330	B. WING		01/10/2012	
	PROVIDER OR SUPPLIE	R	200 CC	ADDRESS, CITY, STATE, ZIP CODE DNNIE AVE I, IN 47167		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	DROUDERS N. AN OF CORRECTION	(X5)	
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	indicated in the	record.				
	On 1/10/12 at 1 provided a police Review of the president not have 3 consecutive delaxative or stood the physician, a day10. If by the resident(s) has a will do an abdot the results of the physician for	2:30 p.m., the DON ey for Bowel Elimination. colicy indicated, "8. Any ring a bowel movement for ays, will be given a I softener, as prescribed by t the end of the 3rd the 4th afternoon, the not had results, the nurse minal assessment, chart the assessment, and notify or further orders." relates to Complaint				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 27 of 46

PRINTED: 02/06/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155330	A. BUILDING B. WING	00	COMPLETED 01/10/2012
	ROVIDER OR SUPPLIER		200 CO	ADDRESS, CITY, STATE, ZIP CODE NNIE AVE , IN 47167	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet Page 28 of 46

STATEMEN	T OF DEFICIENCIES	F DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2			ONSTRUCTION	(X3) DATE SUR	VEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPLETE	D
		155330	B. WIN			01/10/2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				NNIE AVE		
SALEMO	CROSSING				I, IN 47167		
				SALLIVI			
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION				(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re CO	OMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0327 SS=G		provide each resident with					
33-G		ake to maintain proper					
	hydration and he	aith.	FO	327			
l	Based on intervi	ew and record review, the	10	321	F-327 Sufficient fluid to mainta	ain 02	2/09/2012
		ensure a resident received			dydration. SS = GWhat		, 05, 2012
	1	take, resulting in			corrective actions(s) will be		
	•	•			accomplished for those resider		
	_	or dehydration, in 1 of 4			found to have been affected by		
		ed for hydration status, in			the deficient practice?* Reside		
	a sample of 6. R	esident D			D has passed away. How other residents having the potential to		
					be affected by the same deficient		
	Findings include	:			practice will be identified and		
					what corrective actions(s) will I	oe l	
	1 The closed cli	nical record of Resident			taken?* All residents have the		
		on 1/9/12 at 1:30 P.M.			potential to be affected by the		
					alleged deficient practice.*		
		s admitted to the facility			Licensed Nursing staff has bee	en	
		diagnoses including, but			in-serviced on th hydration		
	not limited to, A	cute vertebral fracture,			policy/procedure, assessment and the 3 day intake record by	the	
	Urinary tract info	ection with septicemia,			DNS/designee no later than	uie	
	and Dementia.				1/31/2012. Post test included.	*	
					C.N.A., have been in-serviced		
	A Nursing Admi	ssion Assessment, dated			fluid restrictions/blue form by the	ne	
	_	ed the resident was not			DNS/designee no later than		
	·				1/31/2012. Post test included.*	I	
		or place. The resident's			All residents have been assess	_	
	height and weigh	nt were left blank.			for hydration needs with care p	pian	
					and c.n.a. assignment sheets udated.* Non-compliance with	,	
	A Hydration Ass	sessment, dated 11/7/11,			these practices will result in		
	indicated, "Score	e of 10 or greater will			further education including		
	necessitate super	vision and oversight of			disciplinary action. * Director of	of	
	_	sure hydration needs are			Nursing Services/Designee is		
		nt's total score was 12.			responsible to ensure		
	inct. The reside	into total ocole was 12.			compliance.What measures w		
	1	NT			be put into place or what syste		
		ess Note, dated 11/7/11,			changes will be made to ensur		
	l '	lent admitted on 11-6-11			that the deficient practice does not recur?* Licensed Nursing	•	
	to [room number	f] on a Reg [regular] diet.			staff has been in-serviced on		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet Page 29 of 46

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155330	(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING	(X3) DATE SURVEY COMPLETED 01/10/2012
SALEM (X4) ID	PROVIDER OR SUPPLIER CROSSING SUMMARY STATEMENT OF DEFICIENCIES		, STATE, ZIP CODE ER'S PLAN OF CORRECTION (X5)
PREFIX TAG	Likes and dislikes to be assessed. RD [registered dietician] to follow." A Nutrition Risk Assessment, undated, indicated, "Assessment Type New AdmitDiagnosisUTI [urinary tract infection] [with] septicemiaDementiaHeight (in) 62, Weight (lb) [left blank]Total Fluids [left blank]Diet Order Reg" The remainder of the assessment, including "Oral/Nutrition Intake-Fluid," "Physical and mental functioning," and "Lab Values," was blank. The reverse of the assessment indicated, "Estimating Fluid Needs, Minimum fluid requirement is 1500cc daily" A Resident Care Plan, dated 11/7/11, indicated: "Problem/Need/Concern, Diet-RegInterventions, Record meal % q [every] meal and report changes in appetite. Provide 1500 to 1800 cc fluid with meals every day. Other fluids with med [medication] pass, snacks, hydration pass, and at bedside." The resident's food/fluid intake record, dated November 2011, was reviewed. The record indicated the resident received the following fluids: 11/7/11: 840 cc, 11/8/11: 945 cc, 11/9/11: 1400 cc, 11/10: 660 cc, 11/11: 540 cc, 11/12: 570 cc.	PREFIX TAG hydration p assessmer the DNS/D 1/31/2012. C.N.A., hav fluid restric DNS/Desig 1/31/2012. Non-compl practices w education i action. Hov action(s) w ensure the not recur, i assurance into place? consumptic monitored of tools for hy weekly x 4 months, mo quarterly th residents.* CQI proces monthly lar	completion between the control of th

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 30 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE : COMPL		
		155330	A. BUILDI B. WING	NG 	<u>-</u>	01/10/	2012
	PROVIDER OR SUPPLIE	₹	2	200 COI	DDRESS, CITY, STATE, ZIP CODE NNIE AVE , IN 47167		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PR	ID EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	Nurses Notes in notations:	cluded the following					
		A.M.: "Alert to self only. and] forgetfulness QD					
	[with] confusion notedRequires [activities of dai	P.M.: "Alert to self and forgetfulness [one] assist for ADL's ily living] and transfers.] set-up assist. Appetite fair"					
	11/8/11 at 12:35 selfFeeds self [and] fluid intak	[with] set-up. Appetite					
		P.M.: "Feeds self [with] opetite [and] fluid intake					
	[with] periods of had [two] episod vomitting [sic] of Refuses to eat of for occasional si	00 P.M.: "Alert to person of confusionResident des of 'dry heaves' or clear/white phlegm. r drink anything except ips of soft drink. C/O stomach pain"					
	[with] periods o	55 A.M.: "Alert to person f confusion fluids tonightTemp 99."					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet Page 31 of 46

	OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155330	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMI	E SURVEY PLETED 0/2012
	PROVIDER OR SUPPLIER CROSSING	200 CO	ADDRESS, CITY, STATE, ZIP C NNIE AVE I, IN 47167	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	11/11/11 at 2:00 P.M.: "Feeds self [with] set-up. C/O nausea this day. Is drinking sprite eating saltines"				
	11/11/11 at 10:00 P.M.: "Conts [continues] to sip on sprite and eat saltines"				
	11/12/11 at 11:00 A.M.: "[Alert and oriented] periods of confusionAppetite [and] fluid intake fair"				
	11/12/11 at 6:30 P.M.: "Rsd [resident] lethargicunable to bear weight @ this time. T [temperature] 99.6Family (nurse in family) request CXR [chest x-ray]. Will obtain UA [urinalysis] as well per [name of physician]."				
	11/12/11 at 7:20 P.M.: "[Family member] here. Wants his mother sent to [name of hospital]"				
	11/12/11 at 8:10 P.M.: "EMS [emergency medical services] here. Rsd loaded on cart [and] taken to [name of hospital]."				
	A hospital emergency room record, dated 11/12/11 at 9:40 P.M., indicated, "Physical ExamSkin: poor skin turgor [indicative of dehydration]Impression: 1. Acute Renal Failure/Dehydration"				
	Laboratory results, dated 11/12/11 at				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 32 of 46

	OF CORRECTION IDENTIFICATION NUMBER: 155330	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/10/2012		
	PROVIDER OR SUPPLIER CROSSING	200 CO	ADDRESS, CITY, STATE, ZIP ONNIE AVE I, IN 47167	CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	10:10 P.M., indicated, "Sodium 134 L[low]BUN 64 H [high], Creatinine 2.9 H [high]"					
	On 1/10/12 at 11:15 A.M., during interview with the Director of Nursing [DON], she assisted in deciphering some of the notations on the fluid intake record. The DON indicated the resident was not at the facility very long, and she did not remember much about the resident.					
	On 1/10/12 at 12:15 P.M., during interview with the Dietary Manager [DM], she indicated the resident "was not here long enough" to have been seen by the Registered Dietician, and that is why the nutrition assessment form was not completed. The DM indicated "nursing would document the resident's weight." Upon search through the records, the DM discovered the resident's weight was documented on a vital sign sheet, and was 121.2 pounds upon admission.					
	2. On 1/10/12 at 3/10, the Director of Nursing provided the current facility policy on "Hydration Management," revised 3/10. The policy included: "New admissions scoring 10 or more on the Hydration Assessment will be placed on Intake monitoring for 3 days. 4. The Dietary Services Manager with assistance of the Registered Dietician will determine					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 33 of 46

PRINTED: 02/06/2012 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL. A. BUILDING	E CONSTRUCT 00	HON	COMPL	ETED
		155330	B. WING			01/10/2012	
	PROVIDER OR SUPPLIER		200	ET ADDRESS, CONNIE AV EM, IN 4710			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PERCEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACE	PROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE -REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	5. The Dietary Seassistance of the determine likes a usual amount of tresident. 6. A corwill be written af Hydration Assess record with specipreferences. 7. Fl planned to include for each resident.	ements for each resident. Privices Manager with Registered Dietician will and dislikes including Cluid intake for each Emprehensive care plan are completion of the Ement and 3 day intake and intake will be at least 480 ml/meal" The elates to Complaint					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 34 of 46

PRINTED: 02/06/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155330	A. BUILDING B. WING	00	COMP. 01/10	LETED 0/2012	
SALEM C	ROVIDER OR SUPPLIEI CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 200 CONNIE AVE SALEM, IN 47167				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet Page 35 of 46

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	OVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155330	B. WIN			01/10	/2012
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			NNIE AVE		
SALEMO	CROSSING				, IN 47167		
	DIVOGGING			SALLIVI	, 114 47 107		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0328		ensure that residents					
SS=D		eatment and care for the					
	following special	services:	EC	328			
	Injections;	ntoval fluida.	1.0	320			
	Parenteral and e	riteral fluids; erostomy, or ileostomy care;					
	Tracheostomy ca						
	Tracheal suction						
	Respiratory care	0 .					
	Foot care; and	,					
	Prostheses.						
	Based on observ	rations, interview, and			F-328 Treatment/care for spe		02/09/2012
	record review, th	ne facility failed to ensure			needs.What corrective action(,	
	· ·	was initiated by licensed			will be accomplished for those		
	1	was provided as ordered			residents found to have been		
		nt reviewed related to			affected by the deficient practice?* Resident C is		
					receiving oxygen therapy per		
		gen administration in a			order. Resident C also had no)	
	sample of 6. (Re	esident C)			negative outcome while O2 wa		
					beiing filled.How other residen	its	
	Findings include	:			having the potential to be affe	cted	
					by the same deficient practice		
	During observat	ion of personal care for			be identified and what correcti	ve	
	_	/9/12 at 10:40 a.m., CNA			action(s) will be taken?* All	ho	
		assisted Resident A to			residents have the potential to affected by the alleged deficie		
					practice. * Nursing staff has	iit	
		d to wheel chair. The			been in-serviced on		
	resident was wea	aring oxygen tubing			following Physicians orders ar	nd	
	connected to the	oxygen concentrator set			administering oxygen therapy		
	at 2. The tubing	was switched to a			the DNS/Designee no later that		
	l -	tank hanging at the back			1/31/2012. Post test included		
	1	wheel chair, and CNA #7			C.N.A.'s has been in-serviced		
		<i>'</i>			filling and turning on oxygen b		
		etting on the portable			the DNS/Designee no later tha		
		2." CNA #5 was			1/31/2012. Post test included		
	· ·	, "There's a little still in			Daily rounds will be completed a licensed nurse to ensure	ı by	
	it" in regard to tl	he tank. During interview			residents are receiving oxyger	1	
	at this time, CN	A #5 indicated they would			per Physicians orders.*	•	
		e portable tank based on			Non-compliance with these		
		Т - 1111-11 1111-1111-1111-1111-1111-11					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 36 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, prin ppic	A. BUILDING 00			COMPLETED	
155330		B. WING 01/10/2012				2012	
				FET ADDRESS CITY	Z CTATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER		EET ADDRESS, CITY	r, STATE, ZIP CODE		
04154	0000000			CONNIE AVE			
SALEM	CROSSING		SA	LEM, IN 47167			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVI	DER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL	PREF	X (EACH CORE	RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAC		DEFICIENCY)		DATE
	the setting on th	ne concentrator or as			will result in further		
	indicated on the	e CNA Assignment Sheet.			including disciplinar	'y	
		ted if they "don't know [the			Director of nursing		
		•			esignee is responsil	ble	
	correct setting]	, we go ask.			compliance. What		
					will be put into place		
		CNA Assignment Sheet			emic changes will be nsure that the defici		
	provided by the	ADON during the Initial			oes not recur? *	Ci it	
	Tour of the faci	lity on 1/9/12 at 10:30			Nursing staff has be	en	
		no instruction related to			d on following		
	Resident C's ox				orders/administerir	ng	
	Resident C 5 0x	ygen.		oxygen the	erapy by the		
	0.1/0/10				gnee no later than		
		45 p.m., Resident C was		1/31/2012.			
	observed in the	e physical therapy room,			C.N.A., has been		
	seated in her w	heel chair with leg weights			d on filling and turnir	-	
	on the lower les	gs. The Physical Therapist			by the DNS/design		
	1) was working with the			an 1/31/2012. * Dai	•	
	`	form leg lifts. The resident			I be completed by a urse to ensure		
	•	•			are receiving oxyger	n	
		ula to the nose, and oxygen			cians orders.* All		
	tubing led towa	rd the back of the wheel			orders are reviewed		
	chair. No porta	ıble oxygen tank was on			e DNS/designee wit		
	the back of the	resident's wheel chair.		follow-up u	using the CQI minute	es	
	During intervie	w at this time, the PTA			ure physician orders		
	_	ortable oxygen tank had		-	e and being followe	d. *	
	•				liance with these		
		filling. The PTA obtained		-	will result in further		
		ration meter and applied it			including disciplinar	Ty	
	to the resident's	finger. He indicated the			w the corrective		
	oxygen level flu	uctuated but was at the		` '	vill be monitored to e deficient practice w	vill	
	95-96% range.				i.e., what quality	v!	
					program will be put	t l	
	The clinical rec	ord for Resident C was			?* The CQI audit to		
					therapy will be utilize		
	reviewed on 1/9	9/12 at 12:05 p.m.		weekly x 4	, bi-weekly x 2 mon		
					3 and quarterly		
	Physician's orde	ers for January 2012			* Findings from the	ne	
	included, but w	ere not limited to, "O2		CQI proces	ss will be reviewed		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet Page 37 of 46

PRINTED: 02/06/2012 FORM APPROVED OMB NO. 0938-0391

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155330	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMP	PLETED D/2012
	PROVIDER OR SUPPLIER		200 CC	ADDRESS, CITY, STATE, ZIF DNNIE AVE 1, IN 47167	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PERCEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
		M [liters per minute] to keep sats > [greater		monthly and an action implemented for three 95%.		
	a.m., the Director facility did not ha provision of oxyg indicated she thou change settings for	ught the CNA could not or the oxygen flow rate, would be allowed to set table tank to the				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 38 of 46

PRINTED: 02/06/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155330		LDING	ONSTRUCTION 00	(X3) DATE COMPL 01/10 /	ETED
NAME OF PROVIDER OR SUPPLIER SALEM CROSSING		.	D. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE ONNIE AVE 1, IN 47167		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0431 SS=D	services of a lice establishes a sys and disposition o sufficient detail to reconciliation; an records are in ord	employ or obtain the nsed pharmacist who stem of records of receipt fall controlled drugs in o enable an accurate d determines that drug der and that an account of gs is maintained and noiled.	F0	431			
	must be labeled accepted profess the appropriate a	icals used in the facility in accordance with currently sional principles, and include accessory and cautionary the expiration date when					
	the facility must s biologicals in lock proper temperatu	th State and Federal laws, store all drugs and ked compartments under ure controls, and permit only nnel to have access to the					
	permanently affix storage of contro II of the Comprel Prevention and C drugs subject to facility uses singl distribution syste	provide separately locked, and compartments for alled drugs listed in Schedule mensive Drug Abuse Control Act of 1976 and other abuse, except when the le unit package drug ms in which the quantity and a missing dose can be					
					F-431. Drug records, label/std drugs & biologicals.What corrective action(s) will be accomplished for those reside found to have been affected b the deficient practice?* Resid D has passed away.How othe residents having the potential	nts y ent r	02/09/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet Page 39 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A DIT	LDING	00	COMPLE	TED	
		155330	A. BUI B. WIN			01/10/2	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R					
CALENA	ODOOOINO				NNIE AVE		
SALEMI	CROSSING			SALEIVI	I, IN 47167		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Based on interv	iew and observation, the			be affected by the same defici	ent	
	facility failed to	ensure a controlled			practice will be identified and		
	1	was accounted for, for 1 of			what corrective action(s) will b		
	_	ewed for controlled			taken? * All residents have the	ne	
					potential to be affected by the		
		nitoring, in a sample of 6.			alleged deficient practice.*		
	Resident D				Licensed Nursing staff has be in-serviced on the	en	
					policy/procedure for administe	ring	
	Findings includ	e:			a controlled substance by the	''''g	
					DNS/designee no later than		
	1 The closed wa	ecord of Resident D was			1/31/2012. Post test included	. *	
					Chart audit was completed for		
	reviewed on 1/1	0/12 at 1:30 P.M.			resident with control logs to		
					ensure in place. *		
	A Physician's or	rder, dated 11/7/11,			Non-compliance with these		
	indicated, "Lort	ab [a narcotic pain			practices will result in further		
	-	/500 [one]Q[every] 6 hrs			education including disciplinar	У	
	PRN [as needed				action. Director of Nursing	.	
	as necuce	ıj panı.			services/designee is responsible	ole	
					to ensure compliance. What measure will be put into place	or	
	Nurses Notes in	cluded the following			what systemic changes will be		
	notations:				made to ensure that the deficient		
					practice does not recur?*	J	
	11/7/11 at 1:10	A.M.: "c/o [complains			Licensed Nursing Staff has be	en	
		as given Lortab 7.5-500			in-serviced on the		
		_			policy/procedure for administe	ring	
		gency kit] box. Will			a controlled substance by the		
	continue to mor	nitor."			DNS/Designee no later than		
					1/31/2012. Post test included		
	11/7/11 at 10:00	P.M.: "PRN Lortab			Chart audit was completed for	all	
	given for back r	pain [secondary to]			residents with control logs to		
	surgery"				ensure in place.* Unit		
	2018017				Manager/designee will review MARs/control log daily to ensu		
	11/0/11 -4 12 2/	D.M. II. a/a k1			controlled medications are		
		5 P.M.: "c/o back pain			documented appropriately. *		
	PRN pain meds	given"			Non-compliance with these		
					practices will result in further		
	11/9/11 at 2:00	P.M.: "c/o of [sic] back			education including disciplinar	y	
	pain. PRN Lorta				action. How the corrective		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet Page 40 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	LDING	00	COMPL	ETED
		155330	B. WIN			01/10/	2012
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			NNIE AVE		
SALEM (CROSSING				, IN 47167		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX				PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	A Medication A [MAR], dated Nother resident recession A.M. and Second A.M. and Second A control log resident record. On 1/10/12 at 12 interview with the she indicated the Lortab should he clinical record. I looked in the fill and was unable and was unable as a company the second administered by sign the medicate Federal and state.	dministration Record lovember 2011, indicated eived Lortab on 11/9/11 at 5:00 P.M. garding the administration acking in the clinical 2:00 P.M., during the Director of Nursing, the control log for the ave been kept with the The DON indicated she the and in stacks of papers to locate it. 1:12:30 P.M., the Director N] provided the current the "Controlled atted 7/11. The policy control log will controlled medications. trolled medication is the nurse, the nurse will tion out on the control log. the love and indicated the current the nurse, the nurse will the nurse is the nurse will will the nurse will the nurse is the nurse will will the nurse will wil			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	vill ol vill athly an d	
		cation is accounted for.					
	_	is a part of the resident's					
	permanent clinic	cal record"					
	This federal tag IN00102083.	relates to Complaint					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet Page 41 of 46

PRINTED: 02/06/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155330	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM	TE SURVEY MPLETED 10/2012
SALEM	PROVIDER OR SUPPLIE CROSSING		200 CO	ADDRESS, CITY, STATE, ZIP NNIE AVE , IN 47167	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION SHOULD BE : APPROPRIATE	(X5) COMPLETION DATE
	3.1-25(m)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 42 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING 00 COMPLET.			ETED	
		155330	B. WING 01/10/2012				
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				NNIE AVE		
CVIEWO	CROSSING				, IN 47167		
SALEIVI	CRUSSING			SALEIVI	, 111 47 107		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0514 SS=D	The facility must each resident in a professional stan complete; accura accessible; and s The clinical recor information to ide of the resident's a care and services	maintain clinical records on accordance with accepted dards and practices that are tely documented; readily systematically organized. d must contain sufficient entify the resident; a record assessments; the plan of a provided; the results of any eening conducted by the	F0	514	F-514 Records-complete/accurate/acsible.SS=D What corrective	cce	02/09/2012
	facility failed to was complete regardministration of of 6 residents regarded documentation, in D Findings include 1. The closed regreeiewed on 1/10 A Physician's organizated, "Lortamedication] 7.5/PRN [as needed]	f pain medication, for 1 viewed for clinical in a sample of 6. Resident cord of Resident D was 0/12 at 1:30 P.M. der, dated 11/7/11, ib [a narcotic pain 500 [one]Q[every] 6 hrs			actions(s) will be accomplished for those residents found to habeen affected by the deficient practice. * Resident D has passed away. How other reside having the potential to be affect by the same deficient practice be identified and what correctivaction(s) will be taken?* All residents have the potential to affected by the alleged deficient practice.* Licensed Nursing S has been in-serviced on policy/procedure for administer a pain medication by the DNS/designee no later than 1/31/2012. Post test included. *Unit Managers/designee will review MARs daily to ensure pain medications are documented appropriately.* Non-compliant with these practices will result further education including disciplinary action.* Director on Nursing Services/Designee is responsible to ensure	ents cted will ve be nt taff ring	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 43 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A DIIII	A. BUILDING 00		COMPLETED		
		155330	A. BUII B. WIN	A. BUILDING			2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R					
CALEMA	CDOCCINIC				NNIE AVE		
SALEM	CROSSING			SALEM	, IN 47167		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	ΓE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	-	DATE
	notations:				compliance.What measures w		
					be put into place or what syste		
	11/7/11 at 1·10	A.M.: "c/o [complains			changes will be made to ensur		
					that the deficient practice does	3	
		as given Lortab 7.5-500			not recur?* Licensed Nursing		
		gency kit] box. Will			staff has been in-serviced on	ring	
	continue to mor	nitor."			policy/procedure for administe a pain medication by the	iliy	
					DNS/designee no later than		
	11/7/11 at 10:00	P.M.: "PRN Lortab			1/31/2012. Post test included.	*	
	given for back r	pain [secondary to]			Unit Managers/designee will		
	surgery"	[review MARs daily to ensure p	ain	
	Surgery				medications are documented		
	11/0/11 + 10.0/				appropriately. * Non-complian		
		5 P.M.: "c/o back pain			with these practices will result	in	
	PRN pain meds	given"			further education including		
					disciplinary action. How the		
	11/9/11 at 2:00	P.M.: "c/o of [sic] back			corrective action(s) will be monitored to ensure the deficient	ant	
	pain. PRN Lorta	ab given"			practice will not recur, i.e., wha		
	1				quality assurance program will		
	A Medication A	Administration Record			put into place?* The CQI audi		
		November 2011, indicated			tool for unnecessary medication	ns	
					will be utilized weekly x 4 weel		
		eived Lortab on 11/9/11 at			b-weekly x 2 months, monthly	x 3	
	8:00 A.M. and 3	5:00 P.M. The back side of			and quarterly thereafter. *		
	the MAR, which	h included spaces to write			Findings from the CQI process		
	the "Reason" an	d the "Results/Response"			reviewed monthly and an action plan will be implemented for a		
	were blank.	•			deficient practice below the 95		
					threshold.	70	
	On 1/10/12 at 1	2:30 P.M., during					
		he Director of Nursing					
		_					
		strator, the Administrator					
		standard nursing practice					
	for nursing staff	f to document the					
	administration a	and reason for PRN					
	medication.						
	2 On 1/10/12 or	t 2:00 P.M. the					
	2. On 1/10/12 at	ı ∠.∪∪ r.ıvı., tile					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet Page 44 of 46

PRINTED: 02/06/2012 FORM APPROVED OMB NO. 0938-0391

	of correction identification number: 155330	A. BUILDING B. WING	COMPLETED 01/10/2012
NAME OF PROVIDER OR SUPPLIER SALEM CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 200 CONNIE AVE SALEM, IN 47167	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME DEFICIENCY)	(X5) COMPLETION DATE
	Administrator provided the current facility policy on "Pain Management," revised 3/10. The policy included: "Documentation of administration of ordered PRN [as needed] pain medication will be initialed on the front of the Medication Administration Record (MAR). Additional information including, but not limited to reasons for administration, interventions, and effectiveness of pain medication will be documented on the back of the Medication Administration (MAR), or on the facility specific pain management flow sheet" This federal tag relates to Complaint IN00102083. 3.1-50(a)(1)		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AJ8211

Facility ID: 000223

If continuation sheet

Page 45 of 46

PRINTED: 02/06/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155330	(X2) MULTIPLE CO A. BUILDING B. WING	00	Cor	TE SURVEY MPLETED 10/2012
NAME OF PE	OVIDER OR SUPPLIE	R	200 CO	ADDRESS, CITY, STATE, INNIE AVE , IN 47167	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIE	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN C (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	OF CORRECTION FROM SHOULD BE THE APPROPRIATE CY)	(X5) COMPLETION DATE

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Event ID: AJ8211

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If continuation sheet

Page 46 of 46